

2002 Standards and Checklist Booklet Revisions

The following revisions to the 2002 publication of the AAAASF Standards and Checklist Booklet were initially approved by the Board of Directors at the Spring Board of Directors meeting on April 28, 2002 and final revisions were approved by the Board of Directors at the Fall Board of Directors on November 3, 2002.

The revisions to the standards are highlighted in bold print.

Section 1000, Anesthesia, has been added and includes all new standards.

The page titled, "Important Notice", has been added for further clarification of the requirements for all AAAASF accredited facilities.

IMPORTANT NOTICE

The AAAASF Accreditation Program requires 100% compliance with all standards to be an accredited facility.

All surgeons using the facility must be board certified or board eligible in an ABMS surgical specialty. (See list of acceptable surgical boards below) The facility director must be board certified in an ABMS surgical specialty or an anesthesiologist. Additionally, every surgeon within an AAAASF accredited facility whether the facility is multi-specialty, group practice or a single surgeon facility, must hold valid and unrestricted hospital privileges at a duly accredited and/or licensed hospital for those core privileges in their specialty that are performed within the accredited facility. Only those procedures covered by hospital privileges may be performed within an AAAASF accredited facility.

In addition, multi-specialty ambulatory surgery centers must have a written transfer agreement with a duly accredited and/or licensed hospital in their community.

Changes in facility ownership must be reported in writing to the Central Office within 30 days.

Any death occurring in an accredited facility, or any death occurring within 30 days of a surgical procedure performed in an accredited facility, must be reported to the Central Office within five business days.

Changes in surgical staff must be reported in writing to the Central Office within 30 days.

Accepted ABMS Surgical Specialties:

Colon & Rectal Surgery	Otolaryngology	Neurosurgery
Obstetrics & Gynecology	Plastic Surgery	Thoracic Surgery
Ophthalmology	General Surgery	
Orthopaedic Surgery	Urology	

Pain Management procedures can be performed in an accredited facility by a Board Certified Anesthesiologist or an Anesthesiologist that holds hospital privileges for those same procedures being performed in the facility.

DEFINITION OF FACILITY CLASSES

Not Applicable

If a standard for the Class (A, B or C) does not apply to the situation in this facility, indicate such by **marking N/A** on the answer sheet.

SECTION 100. General Environment

110-050 **There is at least one examination room.**

SECTION 200. OR Environment, Policy and Procedures

210-010 The operating suite is **physically and** distinctly separate and segregated from the General Office Area (waiting room, exam room, administrative area, physician office, staff lounge, etc.).

210-070 The operating room(s) is of a size adequate to allow for the presence of all equipment and personnel necessary for the performance of the surgical procedures.
(It is suggested that a minimum of 48" (4 feet) of clear space be available on each side of the OR table to accommodate emergency personnel and equipment in case of an emergency.)

230-081 **The scrub facility's ceiling surface or drop-in tiles are smooth, washable and free of particulate matter that can be contaminated. (RG "Ancillary Resources")**

250-010 The **OR** ceiling surface or drop-in tiles are smooth, washable and free of particulate matter than can contaminate the operating room. (RG "Ancillary Resources")

261-015 **Oral airways for each type of patient that is treated in your facility. (adult and pediatric)**

270-010 The operating room has an emergency power source, (*e.g. a generator or battery powered inverter*), with sufficient capacity to operate adequate monitoring, anesthesia, surgical equipment, cautery, and lighting a minimum of **two hours** (*if more than one operating room is used simultaneously, an adequate emergency power source should be available for each OR*).

SECTION 500. Blood and Medications

520-020 There is a **bound journal** to record the use of narcotics on individual patients. (RG 500.1-3)

521-015 **A minimum of 1000cc (IV bag or similar container) of preservative free H2O diluent for Dantrolene is available.**

SECTION 600. Medical Records

40 **OR Records (Major Cases) (RG 600.10-11)**

640-001 **A separate Surgical Log is maintained.**

A Surgical Log must include at a minimum:

640-002 **Numerical listing of procedures (either consecutive numbering from the first case done in the facility or consecutive numbers each year).**

640-003 **Date of surgery**

- 640-004 Patient's name and/or identification number
- 640-005 Procedure(s)
- 640-006 Surgeon's name
- 640-007 Type of anesthesia
- 640-008 Name of person administering anesthesia
- 640-009 Name of person(s) assisting surgeon (MD/RN/Scrub Tech/Circulating RN)

SECTION 700. Quality Assurance/Quality Improvement

740-010 All unanticipated Operative Sequelae **which occur within 30 days of surgery** are reviewed , including, but not limited to:

SECTION 800. Personnel

- 810-030 There is a current delineation of hospital privileges for each surgeon. **Copies of each surgeon's delineation of hospital privileges should be maintained on file in the facility.**
- 810-040 There is a copy of the ABMS Board Certificate or certificate of eligibility for each surgeon. **Copies of each surgeon's board certificate should be maintained on file in the facility.**
- 810-050 **Each surgeon must be currently licensed by the State. Copies of each surgeon's license should be maintained on file in the facility.**
- 830-020 There is a regularly employed Registered Nurse **or Physician in accordance with State Law**, currently licensed in the same state as the facility, designated as the person responsible for patient care in the facility.

SECTION 900. Governance

If the facility is used by a single surgeon who is the sole owner of the facility this section does not apply and does not need to be answered.

"Governance" refers to the rules and regulations that are established by the facility. A facility must have a governing document if any of the following apply:

1. more than one surgeon uses the facility, regardless of how often the second surgeon uses the facility;
2. the owner of the facility is someone other than the single surgeon

These rules and regulations must be established by the governing body of the facility whether it be a board of directors or a group of surgeons and key staff members. The governing rules will set the policy of how the individual surgeons within the facility deal with each other and external parties. The most important aspect of the governing rules should cover the surgeon's role in properly dealing with the patient.

If the facility's records in the Central Office indicate that there are more than one surgeon using the facility or that the facility is owned by someone other than a single surgeon, the following questions must be answered. The information in your facility's file **MUST** be current and accurate to assure the facility's accreditation is accurate and is not noted as being deficient erroneously.

The following section applies to facilities that meet either of the conditions noted.

SECTION 1000. Anesthesia (RG 1000.1) (STD 820-850)

Delivery of Anesthetics

- 1000-01 All anesthetics are delivered by a) a qualified physician; b) a CRNA under physician supervision, if required under state or federal law or by a policy adopted by the AAAASF accredited facility; or c) another qualified health care provider under the supervision of a qualified physician.
- 1000-02 The qualified physician who is responsible for supervising the administration of anesthesia must **have** knowledge in anesthetics and resuscitative techniques appropriate for the type of anesthesia being administered.

1010. PRE-ANESTHETIC CARE (These standards apply to all patients who receive anesthesia or sedation/analgesia; in extreme emergencies these standards may be modified and if this is the case all circumstances should be documented in the patients record)

- 1010-10 A physician is responsible for determining the medical status of the patient; and
- 1010-11 Assuring that an anesthesia care plan has been appropriately developed and documented; and
- 1010-12 Assuring that the patient or responsible adult has been informed about the anesthesia care plan

The anesthetic care plan is based on:

- 1010-21 A review of the medical record available
- 1010-22 Medical history
- 1010-23 Prior anesthetic experiences
- 1010-24 Drug therapies
- 1010-25 Medical examination and assessment of any physical conditions that might affect the decision about the preoperative risk management (STD 610, 611, 612)
- 1010-26 A review of medical test and consultations that might reflect on the anesthesia administration
- 1010-27 A determination relative to the appropriate preoperative medications needed for the conduct of anesthesia
- 1010-28 Providing appropriate preoperative instructions and other preparation as needed

1020. ANESTHESIA MONITORING - applicable to all anesthesia though in emergency circumstances life support measures take precedence and may be exceeded based on judgement of the responsible physician. Any waived requirements must have an appropriate statement in the patient records to document reason for same. (RG 1000.2)

1020-01 If responsible for supervising the administration of anesthesia or providing anesthesia, the qualified physician must be physically present in the operating **suite** throughout the conduct of all anesthetics.

**Patient monitoring during anesthesia will consist of:
(RG 200.23, RG 200.24, RG 1000.2)**

Oxygenation

1020-02 Assessed by O2 analyzer if an anesthesia machine is used during general anesthesia which also includes an alarm for low O₂ concentration

1020-03 Pulse oximetry (STD 261)

1020-04 Adequate illumination is available to assess patient color

Ventilation as noted by:

1020-05 Chest excursion

1020-06 Breathing bag reservoir

1020-07 Auscultation of breath sounds

1020-08 Monitoring of end tidal expired CO₂ including volume, Capnography/Capnometry or mass spectroscopy

1020-09 Proper position of the endotracheal tube or laryngeal mask

1021-01 The mechanical ventilator should have a continuous use device which indicates a disconnect via an audible signal

1021-02 Clinical signs are evaluated by continual observation during regional/sedation analgesic

Circulation may be monitored by one or several of the following:

1022-01 Continuous EKG during procedure

1022-02 Arterial blood pressure every 5 minutes (minimum)

1022-03 Heart rate every 5 minutes (minimum)

- 1022-04 Pulse oximetry
- 1022-05 Heart auscultation
- 1022-06 Intra-arterial pressure
- 1022-07 Ultrasound peripheral pulse monitors pulse plethysmography or oximetry
- 1023-11 ***Temperature*** should be monitored when clinically significant changes in body temperature are intended, suspected or anticipated (STD 261)

(“continual” is defined as “repeated regularly and frequently in steady, rapid succession” whereas “continuous” means “prolonged without any interruption at any time”)

1024. POST-ANESTHETIC CARE applies to post anesthesia in all locations and all patients that have received general anesthesia, regional anesthesia, or sedation/analgesia. (Under extenuating circumstances the responsible physician may waive the requirements but it is recommended when this is done it should be so stated including the reasons and noted in the patients record) (STD 310)

- 1024-01 A post anesthetic care unit or area equivalent is available to recover all patients after anesthesia administration
- 1024-02 If a patient is not sent to PACU there is a specific order for the variance that is documented on the record
- 1024-03 Patients transferred to the PACU are accompanied by a member of the anesthesia care team who is knowledgeable about the patient
- 1024-04 Patient transferred to the PACU will be continually evaluated and treated as needed during the transport with appropriate monitoring

1025. EVALUATION IN PACU WILL INCLUDE:

- 1025-01 Documentation of time of arrival
- 1025-02 Assessment and evaluation of the patient by the anesthesia recovery staff
- 1025-03 Transmission of a verbal report to PACU team from a member of the anesthetic team who accompanies the patient
- 1025-04 Transference of any pertinent information concerning the pre-op condition or surgery/anesthesia course
- 1025-05 A member of the anesthesia care team remains in the post anesthesia care area until the post anesthesia care nurse accepts responsibility for the case being transferred

1026. CONTINUED EVALUATION IN THE PACU WILL CONSIST OF: (RG 1000.3)

- 1026-01 Observation and monitoring by methods appropriate to the patient's condition (O2 saturation, ventilation, circulation, temperature)
- 1026-02 Pulse oximetry
- 1026-03 A written, accurate post anesthetic care report is available
- 1026-04 Medical supervision and coordination of patient care is by a physician
- 1026-05 There exists a policy written and documented that a physician is available

1027. DISCHARGE FROM PACU (STD 320)

- 1027-01 A physician is responsible for discharge from the PACU and should be immediately available
- 1027-02 Approved discharge criteria are used
- 1027-03 PACU nurse may determine that the patient meets discharge criteria and the name of the physician accepting responsibility is noted on the record

1029. EQUIPMENT AND SUPPLIES FOR ANESTHESIA SHOULD INCLUDE:

- 1029-01 A reliable source of oxygen, adequate for the length of the procedure. Back up should consist of at least one full E cylinder
- 1029-02 A central source of piped oxygen must meet all applicable codes
- 1029-03 Sufficient space to accommodate the necessary personnel and equipment and monitoring devices is available.
- 1029-04 There is an adequate source of suction
- 1029-05 An adequate and reliable waste anesthetic scavenging system exists if inhalation anesthetics are used
- 1029-06 Self inflating bags, if used, are used they are capable of delivering positive pressure ventilation with at least 90% oxygen concentration
- 1029-07 Adequate anesthesia machines equivalent for that used in the operating room are available in areas where inhalation anesthetics are used

- 1029-08 Sufficient electrical outlets are available, labeled and properly grounded to suit the location (i.e. wet locations, cystoscopy-arthroscopy) and connected to emergency power supplies
- 1029-09 Adequate illumination for patients, machines and monitoring equipment includes battery powered illuminating systems or processes
- 1029-10 Emergency cart is available with defibrillator, necessary drugs and other CPR equipment
- 1029-11 There is a reliable means of two-way communication to necessary personnel in other facility locations
- 1029-12 Appropriate testing as per manufacturer specifications is present (STD 260)
- 1029-13 Sufficient backup power to last at least 120 minutes (STD 270)
- 1029-14 Appropriately sized pediatric medical equipment is available if services are provided to infants/children

1030. QUALITY OF CARE

A licensed or qualified anesthesia provider, functioning in the facility, should participate in quality assurance and risk management functions appropriate to the facility (STD 710-720)

- 1030-01 The surgeon and the licensed or qualified anesthesia provider concur on the appropriateness of the procedures performed at the facility based on the qualifications of the providers and the facility resources.
- 1030-02 Procedures should be of a duration and degree to permit necessary recovery and discharge from the facility
- 1030-03 A patient who by reason of pre-existing or other medical condition is at undue risk should be referred to alternative facilities that are more appropriate

1031. TRANSFERS/EMERGENCIES (STD 320, 330, 420, 421)

- 1031-01 Anesthesia personnel should review and be familiar with the facility's written emergency protocol for cardio-pulmonary emergencies and other internal and external disasters
- 1031-02 Anesthesia personnel should be appropriately trained and knowledgeable about the facilities protocols for a safe and timely transfer of patient to a pre-specified alternative care facility when extended or emergency services are required for the well being of the patient

SECTION 1000 Approved by the American Association for Accreditation of Ambulatory Surgery Facilities Board of Directors on May 6, 2001.